		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019596

Facility Name: Alden Morrow Rehab & HCC

Address: 5001 S. Michigan Ave. (Number) Chicago (City) 60615 (Zip Code)

County: Cook

Telephone Number: (773) 286-3883 **Fax #** (773) 286-3743

IDPA ID Number: 36-2814943

Date of Initial License for Current Owners: 11/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll **Telephone Number:** (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steven M. Kroll

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	192	Skilled (SNF)	192	70,080	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	192	TOTALS	192	70,080	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,194	83	955	8,232	8
9	SNF/PED					9
10	ICF	24,127	0	132	24,259	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,321	83	1,087	32,491	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.36%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 01/04/1976

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 18 and days of care provided 808

Medicare Intermediary AdminiStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	161,128	20,103		181,231	494	181,725		181,725			1
2	Food Purchase		196,554		196,554	(21,322)	175,232	(17,341)	157,891			2
3	Housekeeping	103,725	14,395		118,120	87	118,207		118,207			3
4	Laundry	38,334	6,270		44,604	62	44,666		44,666			4
5	Heat and Other Utilities			186,702	186,702		186,702		186,702			5
6	Maintenance	31,288		121,997	153,285	40	153,325	13,209	166,534			6
7	Other (specify):*											7
8	**TOTAL General Services**	334,475	237,322	308,699	880,496	(20,639)	859,857	(4,132)	855,725			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	832,979	35,280	4,608	872,867	3,174	876,041	(5,514)	870,527			10
10a	Therapy											10a
11	Activities	50,230	2,774	2,104	55,108	39	55,147		55,147			11
12	Social Services	29,745		840	30,585		30,585		30,585			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	912,954	38,054	19,552	970,560	3,213	973,773	(5,514)	968,259			16
	C. General Administration											
17	Administrative	127,176			127,176		127,176		127,176			17
18	Directors Fees											18
19	Professional Services			665,280	665,280	(14,000)	651,280	(593,754)	57,526			19
20	Dues, Fees, Subscriptions & Promotions			22,823	22,823		22,823	(11,480)	11,343			20
21	Clerical & General Office Expenses	194,822	13,705	34,583	243,110	27	243,137	23,892	267,029			21
22	Employee Benefits & Payroll Taxes			230,929	230,929	17,399	248,328	40,968	289,296			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,150	1,150		1,150	7,132	8,282			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			101,931	101,931		101,931	(5,568)	96,363			26
27	Other (specify):*			(47,239)	(47,239)		(47,239)	47,239				27
28	**TOTAL General Administration**	321,998	13,705	1,009,457	1,345,160	3,426	1,348,586	(491,571)	857,015			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,569,427	289,081	1,337,708	3,196,216	(14,000)	3,182,216	(501,217)	2,680,999			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Alden Morrow Rehab & HCC #0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			72,118	72,118		72,118	79,029	151,147			30
31	Amortization of Pre-Op. & Org.							663	663			31
32	Interest			94,906	94,906		94,906	64,113	159,019			32
33	Real Estate Taxes			199,299	199,299	14,000	213,299	3,848	217,147			33
34	Rent-Facility & Grounds			581,420	581,420		581,420	(581,057)	363			34
35	Rent-Equipment & Vehicles			7,887	7,887		7,887	13,544	21,431			35
36	Other (specify):*							8,395	8,395			36
37	**TOTAL Ownership**			955,630	955,630	14,000	969,630	(411,465)	558,165			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		39,890	74,692	114,582		114,582	(43,435)	71,147			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			105,120	105,120		105,120		105,120			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		39,890	179,812	219,702		219,702	(43,435)	176,267			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,569,427	328,971	2,473,150	4,371,548		4,371,548	(956,116)	3,415,432			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	66,942	30		9
10	Interest and Other Investment Income	(6)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	352	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,320)	32		18
19	Entertainment				19
20	Contributions	(4,888)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	47,239	27		24
25	Fund Raising, Advertising and Promotional	(3,196)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,878)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 101,245		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(547,432)	pg 6's	34
35	Other- Attach Schedule	(509,929)	pg 5a	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,057,361)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (956,116)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Alden Morrow Rehab & HCC

ID# 0019596

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	non-cost: hmo drugs c/a (gl 5042)	$ (919)	39	1
2	non-cost: hmo therapy c/a (gl 5040)	(3,164)	39	2
3	non-cost: part b c/a's (in gls 5212/5213/5214)	(160)	39	3
4	Eliminate rent due to sale/leaseback	(581,420)	34	4
5	Mortgage interest	136,698	32	5
6	MIP insurance	8,395	36	6
7	tax interest (gl 8102)	(251)	32	7
8	PAC FEES (in gl 5721: part of IHCA)	(691)	20	8
9	Back out prior year (2000) cr adjust. in gl 5713	22,041	19	9
10	Delete AMS interest charged, gl 7105	(92,334)	32	10
11	record deprec exp on painting reclassed in 1999	4,815	6	11
12	record deprec exp on painting reclassed in 2000	2,629	6	12
13	Late audit adj to correct insur costs($29/bed)	(5,568)	26	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(509,929)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	352	0	0	(17,693)	0	0	0	0	0	0	0	(17,341)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	7,444	0	5,779	0	0	0	(14)	0	0	0	0	13,209	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	7,796	0	5,779	(17,693)	0	0	(14)	0	0	0	0	(4,132)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(5,197)	(317)	0	0	0	0	0	0	(5,514)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(5,197)	(317)	0	0	0	0	0	0	(5,514)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	22,041	0	(615,795)	0	0	0	0	0	0	0	0	(593,754)	19
20	Fees, Subscriptions & Promotions	(11,653)	0	173	0	0	0	0	0	0	0	0	(11,480)	20
21	Clerical & General Office Expenses	0	0	16,728	6,240	924	0	0	0	0	0	0	23,892	21
22	Employee Benefits & Payroll Taxes	0	0	40,779	0	189	0	0	0	0	0	0	40,968	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	7,132	0	0	0	0	0	0	0	0	7,132	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(5,568)	0	0	0	0	0	0	0	0	0	0	(5,568)	26
27	Other (specify):*	47,239	0	0	0	0	0	0	0	0	0	0	47,239	27
28	**TOTAL General Administration**	52,059	0	(550,983)	6,240	1,113	0	0	0	0	0	0	(491,571)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	59,855	0	(545,204)	(16,650)	796	0	(14)	0	0	0	0	(501,217)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	66,942	0	11,855	0	232	0	0	0	0	0	0	79,029	30
31	Amortization of Pre-Op. & Org.	0	0	134	0	0	529	0	0	0	0	0	663	31
32	Interest	41,786	0	21,021	0	354	952	0	0	0	0	0	64,113	32
33	Real Estate Taxes	0	0	3,788	0	60	0	0	0	0	0	0	3,848	33
34	Rent-Facility & Grounds	(581,420)	0	363	0	0	0	0	0	0	0	0	(581,057)	34
35	Rent-Equipment & Vehicles	0	0	13,544	0	0	0	0	0	0	0	0	13,544	35
36	Other (specify):*	8,395	0	0	0	0	0	0	0	0	0	0	8,395	36
37	**TOTAL Ownership**	(464,297)	0	50,705	0	646	1,481	0	0	0	0	0	(411,465)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(4,243)	0	0	(3,011)	(6,883)	(29,298)	0	0	0	0	0	(43,435)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(4,243)	0	0	(3,011)	(6,883)	(29,298)	0	0	0	0	0	(43,435)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(408,684)	0	(494,499)	(19,661)	(5,441)	(27,817)	(14)	0	0	0	0	(956,116)	45

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100%	See page 6k… too many to fit here…				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits	$	Alden Management Services, Inc.	100.00%	$ 40,779	$ 40,779	15
16	V	19	Management fees	622,080	Alden Management Services, Inc.		6,285	(615,795)	16
17	V	21	Gen'l & Admin.		Alden Management Services, Inc.		16,728	16,728	17
18	V	6	maintenance/utilities		Alden Management Services, Inc.		5,779	5,779	18
19	V	24	autos/seminars		Alden Management Services, Inc.		7,132	7,132	19
20	V	20	dues/subscriptions		Alden Management Services, Inc.		173	173	20
21	V	30	depreciation		Alden Management Services, Inc.		11,855	11,855	21
22	V	31	amortization		Alden Management Services, Inc.		134	134	22
23	V	33	real estate tax		Alden Management Services, Inc.		3,788	3,788	23
24	V	34	rent		Alden Management Services, Inc.		363	363	24
25	V	35	rent-equipt/vehicles		Alden Management Services, Inc.		13,544	13,544	25
26	V	32	interest		Alden Management Services, Inc.		21,021	21,021	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 622,080			$ 127,581	$ * (494,499)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	tube feeding	$ 24,678	Pyramid Health Care Services	100.00%	$ 6,985	$ (17,693)	15
16	V	10	nursing supplies	6,274	Pyramid Health Care Services		1,077	(5,197)	16
17	V	39	supplies/per diem fees	7,344	Pyramid Health Care Services		4,333	(3,011)	17
18	V	21	gen'l & admin.		Pyramid Health Care Services		6,240	6,240	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 38,296			$ 18,635	$ * (19,661)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	drugs	$ 22,479	Forum Extended Care II	100.00%	$ 17,614	$ (4,865)	15
16	V	10	house stock	1,463	Forum Extended Care II		1,146	(317)	16
17	V	39	iv	9,325	Forum Extended Care II		7,307	(2,018)	17
18	V	22	fringe benefits		Forum Extended Care II		189	189	18
19	V	21	gen'l & admin.		Forum Extended Care II		924	924	19
20	V	32	Interest		Forum Extended Care II		354	354	20
21	V	33	real estate tax		Forum Extended Care II		60	60	21
22	V	30	depreciation		Forum Extended Care II		232	232	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 33,267			$ 27,826	$ * (5,441)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	CPT REVENUES	$ 60,135	Community Physical Therapy	100.00%	$ 30,837	$ (29,298)	15
16	V	31	Amortization		Community Physical Therapy		529	529	16
17	V	32	Interest		Community Physical Therapy		952	952	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 60,135			$ 32,318	$ * (27,817)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	maintenance expense	$ 2,190	Alden Bennett Constuction	100.00%	$ 2,176	$ (14)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,190			$ 2,176	$ * (14)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Floyd Schlossberg a.	President	Chief Executive	100.00	346,390	1.92	3.20	salary	$ 11,435	21-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.	0.00	77,550	1.92	3.20	salary	2,560	21-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten	0.00	70,845	1.92	3.20	salary	2,339	21-1	3
4											4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10											10
11											11
12											12
13								TOTAL	$ 16,334		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Alden Management Services, Inc.
Street Address: 4200 W. Peterson
City / State / Zip Code: Chicago, IL 60646
Phone Number: (773-286-3883
Fax Number: (773-286-3743

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		see attached schedule…				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Pro Forma allocation of						$	$			$	1
2	interest expense prior to											2
3	sale/leaseback		x	mortgage	$15,474.67	3/7/75	2,166,900	1,630,073	8/20/17	8.2500	136,698	3
4												4
5												5
	Working Capital											
6												6
7	related party-AMS/FECII	x		operations(AMS=21,021)	none		(note: FECII=354)			varies	21,375	7
8	RELATED PARTY - CPT	x		operations	none					varies	952	8
9	TOTAL Facility Related				$15,474.67		$ 2,166,900	$ 1,630,073			$ 159,025	9
	B. Non-Facility Related*											
10	Offset interest expense											10
11	w/ interest income (gl 4301)		x	operations	none						(6)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6)	14
15	TOTALS (line 9+line14)						$ 2,166,900	$ 1,630,073			$ 159,019	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 242,834	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 217,133	2
3. Under or (over) accrual (line 2 minus line 1).		$ (25,701)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 225,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 14,000	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 213,299	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	239,476	8
	1997	228,762	9
	1998	232,823	10
	1999	231,271	11
	2000	217,133	12

LINE 4: PAID IN 2001: $217,133 X 1.03% ESTIMATED INCREASE = $225,000 ESTIMATE.

note: FECII=60

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Morrow Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0019596

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-10-120-001-0000	Nursing home facility	$ 27,141.60	$ 27,141.60
2.	20-10-120-002-0000	Nursing home facility	$ 27,141.60	$ 27,141.60
3.	20-10-120-003-0000	Nursing home facility	$ 27,141.60	$ 27,141.60
4.	20-10-120-004-0000	Nursing home facility	$ 27,141.60	$ 27,141.60
5.	20-10-120-005-0000	Nursing home facility	$ 27,141.60	$ 27,141.60
6.	20-10-120-006-0000	Nursing home facility	$ 27,141.60	$ 27,141.60
7.	20-10-120-007-0000	Nursing home facility	$ 27,141.60	$ 27,141.60
8.	20-10-120-008-0000	Nursing home facility	$ 27,141.60	$ 27,141.60
9.			$	$
10.			$	$
		TOTALS	$ 217,132.80	$ 217,132.80

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior brick Frame steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [x] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	nursing home		1974	$ 80,500	1
2					2
3	TOTALS			$ 80,500	3

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	192		1976	1976	$ 1860675	$	30	$ 62023	$ 62,023	$ 1547496	4
5			1976	1976	147556		30	4919	4,919	123659	5
6	Related Party-Forum			1978	18,359		22			18,359	6
7											7
8	Related Party-Forum Extended Care										8
	Improvement Type**										
9	Related Party-Forum:										9
10	Leasehold Improvement-Remodeling			1980	19,335		20			19,335	10
11	Leasehold Improvement-Remodeling			1980	1,208		10			1,208	11
12	Leasehold Improvement-Remodeling			1986	645		5			645	12
13	Leasehold Improvement-Remodeling			1990	404		5			404	13
14	Leasehold Improvement-Remodeling			1991	94		5			94	14
15	Leasehold Improvement-Remodeling			1993	8,304	830	10	830		7,474	15
16	Leasehold Improvement-Remodeling			1993	6,504	671	9.7	671		6,035	16
17	Leasehold Improvement-sign			1994	261	22	12	22		174	17
18	Leasehold Improvement-dryvit			1995	443	44	10	44		310	18
19	Leasehold Improvement-new ac			1999	723	48	15	48		145	19
20	Leasehold Improvement-roof			1985	972	51	19	51		870	20
21	Leasehold Improvement-roof			1994	863	58	15	58		460	21
22	Leasehold Improvement-roof			1997	819	55	15	55		273	22
23	Leasehold Improvement-roof			1998	1,390	93	15	93		371	23
24	Leasehold Improvement-parking lot asphalt			2000	111	11	10	11		22	24
25	Leasehold Improvement-hallway lighting			2001	155	16	10	16		16	25
26	Leasehold Improvement-DAI			2001	195	19	10	19		19	26
27											27
28	Related Party-AMS:										28
29	Leasehold Improvement-Remodeling			1993	4,266		7			4,266	29
30	Leasehold Improvement-Remodeling			1994	2,112	64	7	64		2,112	30
31											31
32	Related Party-Forum Extended Care				947	50		50		73	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ELEVATOR	1976	$ 70,500	$	25	$	$	$	37
38	AIR CONDITIONER/PAINTING/SMOKE DRAPERIES	1978	14,584		4,7 & 8				38
39	DOOR/ESECT REPAIR/PANELS	1979	3,382		4 & 8				39
40	PAINTING	1981	7,954		3 & 5				40
41	PAINTING/ELECTRICAL WIRING/ELEVATOR REPAIR/A/C	1982	20,715		3,6,8 & 10				41
42	CHIMNEY/BASEBOARDS	1983	8,216		10 & 18				42
43	HOT WATER SYSTEM	1984	4,288		10				43
44	WALL/HANDRAIL/PLUMBING/ELECT REPAIR/PAINT/HVAC	1985	33,370		3,10 & 20				44
45	HEATING/PAINTING/MISC. REPAIR	1986	33,351		3,4,5,10&20				45
46	REPLACE CLOSET DOORS	1991	2,201		5				46
47	LOCKS/ROOFING	1994	9,675	968	10	968		6,934	47
48	REPLACE LEAKING PUMP	1995	2,057	137	15	137		914	48
49	WASCOMAT WASHTOWN	1987	2,175		3			2,175	49
50	WHEELCHAIR REPAIR/PLUMBING/PAINTING/CARPENTRY	1988	35,223		5 & 10			35,223	50
51	PLUMBING/MISC. REPAIRS	1989	21,020		5			21,020	51
52	ELEVATOR REPAIR	1990	2,900		5			2,900	52
53	REPLACE BLOWER MOTOR/FREEZER/CONDENSOR/BOILER	1991	22,644		5			22,644	53
54	FIRE ALARM/REPAIR PUMP/ELEVATOR REPAIR/MISC.	1992	30,274	310	5,10 & 15	310		29,015	54
55	REPAIR 3-WAY VALVES/AIR CONDENSOR/CAULKING/MSC	1993	14,638		5			14,638	55
56	ROOFING	1994	12,070	1,207	10	1,207		9,050	56
57	CONTROLS/PIPING/ROOF/VALVES/AC MOTOR & PUMP/MSC	1995	58,213	1,828	5,10,15&20	1,828		44,905	57
58	BOILER LEAKING & REPLACE TUBES	1996	7,674	512	15	512		2,899	58
59	BOILER TUBE	1996	5,700	380	15	380		2,027	59
60	BOILER TUBE	1996	5,699	380	15	380		1,963	60
61	HVAC	1996	238,155	9,526	25	9,526		50,013	61
62	INSTALL ELECTRICAL WIRING FOR DRYERS	1996	1,838	337	5	337		1,838	62
63	ABC-drywall for dryers	1996	1,105		5			1,105	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,745,962	$ 17,616		$ 84,558	$ 66,942	$ 1,983,081	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,745,962	$ 17,616		$ 84,558	$ 66,942	$ 1,983,081	1
2	INSTALL SPRINKLER HEADS	1998	1,879	376	5	376		1,347	2
3	REPAIR FREON LEAKS	1998	5,391	1,078	5	1,078		3,864	3
4	REPAIR CHILLER	1998	4,930	493	10	493		1,725	4
5	REPAIR CONVECTION STEAMER	1998	2,230	223	10	223		762	5
6	ELECTRICAL WORK	1998	1,901	190	10	190		634	6
7	AIR CONDITIONERS	1998	68,504	4,567	15	4,567		15,223	7
8	AIR CONDITIONERS	1998	10,000	667	15	667		2,222	8
9	INSTALL DOOR RESTRICTOR	1998	3,400	170	20	170		652	9
10	ABC-CONCRETE PATIO	1999	7,346	735	10	735		1,592	10
11	Atash Fire & Safety Equipment (install alarm)	1999	12,400	827	15	827		2,480	11
12	Climate Service (repair leaks and air/water heating)	1999	10,519	701	15	701		2,104	12
13	Alden Bennett Construction(general construction)	1999	2,648	265	10	265		618	13
14	Climate Service(repair)	1999	1,676	112	15	112		251	14
15	Climate Service (repair pipes)	1999	1,565	104	15	104		226	15
16	Alden Bennett Construction(general construction)	1999	922	184	5	184		384	16
17	Alden Bennett Construction(general construction)	1999	6,329	633	10	633		1,318	17
18	Alden Bennett Construction(general construction)	1999	3,598	360	10	360		750	18
19	Alden Bennett Construction(general construction)	1999	4,089	409	10	409		852	19
20	Security Services Group(window detector system)	1999	4,687	312	15	312		677	20
21	CSI-fixed leaking coil	1998	3,526	705	5	705		2,527	21
22	ABC-various leasehold improvements	1999	45,440	4,544	10	4,544		9,088	22
23	Climate Service Inc (repair HVAC)	2000	1,696	113	15	113		226	23
24	Climate Service Inc (repair HVAC)	2000	2,283	152	15	152		304	24
25	Climate Service Inc (repair HVAC)	2000	1,509	94	16	94		189	25
26	GT Mechanical Inc	2000	5,000	222	15	222		556	26
27	Alden Bennett Construction (general construction)	2000	11,602	677	10	677		1,837	27
28	Alden Bennett Construction (general construction)	2000	16,663	833	10	833		2,500	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,987,695	$ 37,363		$ 104,305	$ 66,942	$ 2,037,987	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,987,695	$ 37,363		$ 104,305	$ 66,942	$ 2,037,987	1
2	Fox Valley (ansulator)	2000	2,007	201	10	201		284	2
3	CSI Coker Service (kitchen dishwasher)	2000	3,487	349	10	349		378	3
4	Alden Bennett Construction	2000	4,436	444	10	444		702	4
5	Alden Bennett Construction	2000	7,346	735	10	735		1,102	5
6	Alden Bennett Construction	2000	21,382	2,138	10	2,138		3,207	6
7	Alden Bennett Construction (leashold imprv.)	2000	8,803	880	10	880		1,541	7
8	Long Elevator (replace elevator cable)	2001	2,650	110	10	110		110	8
9	Long Elevator (replace elevator cable)	2001	2,650	88	10	88		88	9
10	Capps (install new water pipes in basement)	2001	4,400	73	25	73		73	10
11	Equipment Internt'l (Drier repair)	2001	1,178	79	5	79		79	11
12	Equipment Internt'l (Drier repair-parts for above repair)	2001	114	8	5	8		8	12
13	GT Mechanical (install exhaust fan: dishwasher)	2001	4,400	147	10	147		147	13
14	Sentry Protection (2 smoke detectors-boiler room)	2001	1,576	66	10	66		66	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,052,125	$ 42,680		$ 109,622	$ 66,942	$ 2,045,772	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 331,558	$ 31,664	$ 31,664	$	varies	$ 193,767	71
72	Current Year Purchases	9,928	400	400		varies	400	72
73	Fully Depreciated Assets	124,548	4,236	4,236		varies	124,548	73
74	unlocated adjustment		1,427	1,427				74
75	TOTALS	$ 466,034	$ 37,728	$ 37,728	$		$ 318,716	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	various	bus/van	1998-2000	$ 11,938	$ 3,797	$ 3,797	$	3	$ 6,200	76
77										77
78										78
79										79
80	TOTALS			$ 11,938	$ 3,797	$ 3,797	$		$ 6,200	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,610,597	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 84,205	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 151,147	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 66,942	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,370,688	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	n/a	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$ n/a	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Omega Healthcare Investors

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [x] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		192	10/29/86	$	10	5	3
4	Additions							4
5								5
6								6
7	TOTAL		192		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: right of first refusal *

10. Effective dates of current rental agreement:
Beginning 10/31/86
Ending 10/31/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ 581,420
13.	/2003	$ 581,420
14.	/2004	$ 581,420

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 7,887 Description: copy machine lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	related party	various	$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Skilled nursing is already on site.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 27,427	$		$ 27,427	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			780			780	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			31,928			31,928	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	see pg 16A	# of prescrpts				18,032		18,032	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	see pg 16A					(7,019)		(7,019)	13
14	TOTAL			$		$ 60,134	$ 11,013		$ 71,147	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Alden Morrow Rehab & HCC **#** 0019596 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,366	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (125,000)	512,501		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	99,150		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	213,063		8
9	Other(specify): escrows	7,088		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 839,168	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	989,079		15
16	Equipment, at Historical Cost	404,158		16
17	Accumulated Depreciation (book methods)	(770,077)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 623,160	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,462,327	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,025,762	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	149,290		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	134,043		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,872		31
32	Accrued Real Estate Taxes(Sch.IX-B)	131,015		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accr exp & due to idpa	169,647		36
37	due to affiliates	15,052		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,645,680	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,645,680	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (183,353)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,462,327	$	48

***(See instructions.)**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 450,930	1
2	Restatements (describe):		2
3	external auditor adjustments made after 2000 cost report		3
4	was filed: these adjustements have no effect on		4
5	reimbursable costs: bad debt exp/medicare revenue…	169,479	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 620,409	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(803,762)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (803,762)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (183,353)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,241,939	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,241,939	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,502	6
7	Oxygen	1,091	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 9,593	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	22,744	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 22,758	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscell.	140	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 140	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,274,436	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	874,527	31
32	Health Care	964,919	32
33	General Administration	1,057,774	33
	B. Capital Expense		
34	Ownership	955,630	34
	C. Ancillary Expense		
35	Special Cost Centers	120,229	35
36	Provider Participation Fee	105,120	36
	D. Other Expenses (specify):		
37	Note: this will not balance to pg 3 & 4 due to related		37
38	party information input to these pages.		38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,078,198	40
41	**Income before Income Taxes (line 30 minus line 40)****	(803,762)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (803,762)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not avail. **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,137	2,287	$ 70,245	$ 30.71	1
2	Assistant Director of Nursing	1,856	1,971	50,377	25.56	2
3	Registered Nurses	5,154	5,514	102,299	18.55	3
4	Licensed Practical Nurses	13,286	14,554	268,719	18.46	4
5	Nurse Aides & Orderlies	37,614	40,835	308,643	7.56	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,838	2,080	21,706	10.44	9
10	Activity Assistants	3,398	3,858	28,524	7.39	10
11	Social Service Workers	1,976	2,080	29,745	14.30	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,080	28,848	13.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,943	17,734	132,280	7.46	15
16	Dishwashers					16
17	Maintenance Workers	1,836	2,080	25,318	12.17	17
18	Housekeepers	13,179	15,004	103,724	6.91	18
19	Laundry	5,547	5,986	38,362	6.41	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,368	4,638	34,699	7.48	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,385	1,659	32,696	19.71	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	111,509	122,360	$ 1,276,185 *	$ 10.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,104	11-3	44
45	Social Service Consultant	12	630	12-3	45
46	Other(specify)				46
47		4	210	12-3	47
48					48
49	TOTAL (lines 35 - 48)	56	$ 2,944		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ n/a		50
51	Licensed Practical Nurses		n/a		51
52	Nurse Aides		n/a		52
53	TOTAL (lines 50 - 52)		$ n/a		53

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
R Agpasa	administrator	0	$ 2,416
various executives	executive mgtmnt	0	37,048
D Dalicandro	administrator	0	2,157
Dipaolo	administrator	0	4,392
R Glantz	administrator	0	730
F Osemwngie	administrator	0	75,921
J Palazzo($2382)/Weber($2129)	administrator	0	4,512
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 127,176

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Alden Management Serv	management fee	$ 622,080
Blackman Kallick	accounting fee	9,100
Barry Greenberg	legal fees	17,309
Ken Fisch	legal fees	17,156
Janet Hermann	legal fees	1,735
First Real Estate	real estate valuators	3,000
Mayer,Brown,Platt	real estate valuators	11,000
HBCC	audit fee	3,500
year 2000 adjustment	backed out on pg 5a…	(22,041)
Misc. vendors	miscell. costs	713
US Gas & Energy	cost auditors	1,728
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 665,280

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,284
Unemployment Compensation Insurance	14,258
FICA Taxes	111,270
Employee Health Insurance	7,673
Employee Meals	21,322
Illinois Municipal Retirement Fund (IMRF)*	
Chicago head tax	(832)
Union/health/welfare	41,157
Employee relations	9,560
Pension	11,522
Miscell costs	1,114
Related party	40,968
TOTAL (agree to Schedule V, line 22, col.8)	$ 289,296

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	49
Health Care Worker Background Check	
(Indicate # of checks performed 53)	371
City of Chicago lic fee	2,982
Sec of State report fee	50
AHCA	100
IHCA	7,618
related party	173
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,343

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Faith Osemwengie	500
related party	7,132
Seminar Expense	
Glantz Richman	225
Faith Osemwengie	425
related party	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,282

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Alden Morrow Rehab & HCC # 0019596 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	hvac/painting	1-10/89	$ 36,448	5	$	$	$	$	$	$	$	$	$
2	hvac repair	8/90	2,612	5									
3	hvac/painting/boiler rep's.	6-11/92	18,988	3-15	224	224	224	224	224	224	224	224	
4	pump/paint./compress.	1-10/93	32,016	3									
5	painting/pump repairs	2-11/94	10,007	3	0								
6	painting	4-12/95	7,922	3	1,640	0							
7	hvac/pipes/boiler/paint'g	1-12/96	61,716	3-20	13,276	5,092	2,579	1,831	1,831	1,831	1,831	1,831	1,831
8	hvac repairs	1-12/97	22,597	3	7,532	7,532	2,872	0					
9	replace actuator/hvac	9/98	1,872	3	208	624	624	416	0				
10	repair a/c-Chic. Cool'g	10/99	3,529	3		294	1,176	1,176	882				
11	Painting>$1,500 ytd ***	7/99	14,444	3		2,407	4,815	4,815	2,408				
12	GT Mechanical (repair Va	5/00	2,168	3			482	723	723	240	0		
13	Alden Bennett (painting)	4/00	14,701	3			3,675	4,900	4,900	1,226	0		
14	Alden Bennett (landscapi	4/00	1,337	3			334	446	446	111	0		
15	GT Mechanical	10/00	2,949	3			246	983	983	737	0		
16	painting>$1500 ytd ***	7/00	7,887	3			1,315	2,629	2,629	1,315	0		
17	no additions in 2001												
18													
19													
20	TOTALS		$ 241,194		$ 22,880	$ 16,173	$ 18,342	$ 18,143	$ 15,026	$ 5,684	$ 2,055	$ 2,055	$ 1,831

Facility Name & ID Number Alden Morrow Rehab & HCC **#** 0019596 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $7,618**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **6 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,584** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **YES**
If YES, give effective date of lease. **10/29/86**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **105,120**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,322** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **BDO Seidman, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.